

**VIRGINIA DEPARTMENT OF HEALTH DIVISION OF TUBERCULOSIS (TB) CONTROL ~ TB CONTACT INVESTIGATION FORM (TB 502)**

<b>Case ID #:</b> _____ <b>District:</b> _____ <b>Case Manager:</b> _____ <b>Case Manager Phone:</b> _____ <b>Investigation Type:</b> <input type="checkbox"/> General <input type="checkbox"/> Special Site → <b>Location:</b> _____ <b>Site Contact Person:</b> _____ <b>Site Contact Phone:</b> _____						<b>Case Type (check one)</b> ___ Pulmonary, smear positive ___ Pulmonary, smear negative ___ Extrapulmonary TB ___ Source		<b>Probable Infectious Period:</b> Start Date: _____ Stop Date: _____	
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Contact Name, Address, Telephone Number, and Date of Birth (DOB)	Relation to Case and Priority in Investigation	History of Positive TST or Treatment for LTBI	Initial TST and Symptom Review	TST Follow-up and Symptom Review	Chest X-Ray	Treatment of LTBI			Comments
						No	Yes	Check Reason Treatment Stopped or Not Recommended	
DOB: ____/____/____	Relation to Case:  Priority in Investigation: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	TST Date: _____ Result: _____ mm  Prior Tx Dates:  Prior Tx Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Result: _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative  <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic	Date: _____ Result: _____ mm <input type="checkbox"/> Pos <input type="checkbox"/> Neg  Conversion? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic	Date: _____  <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Start Date: _____  Stop Date: _____	<input type="checkbox"/> Completed <input type="checkbox"/> Refused <input type="checkbox"/> Contraindicated <input type="checkbox"/> Died <input type="checkbox"/> Self-stopped <input type="checkbox"/> Toxicity <input type="checkbox"/> Active TB diagnosed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved to _____ <input type="checkbox"/> Other _____	
DOB: ____/____/____	Relation to Case:  Priority in Investigation: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	TST Date: _____ Result: _____ mm  Prior Tx Dates:  Prior Tx Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Result: _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative  <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic	Date: _____ Result: _____ mm <input type="checkbox"/> Pos <input type="checkbox"/> Neg  Conversion? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic	Date: _____  <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Start Date: _____  Stop Date: _____	<input type="checkbox"/> Completed <input type="checkbox"/> Refused <input type="checkbox"/> Contraindicated <input type="checkbox"/> Died <input type="checkbox"/> Self-stopped <input type="checkbox"/> Toxicity <input type="checkbox"/> Active TB diagnosed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved to _____ <input type="checkbox"/> Other _____	
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